STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-5254   1-800-852-3345 Ext. 5254
Fax: 603-271-8431   TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

Limited Use Hospital Discharge Data Set
Application and Data Use Agreement

Please **send** your completed application materials to the following address:

Andrew Chalsma
Bureau of Data & Systems Management
Office of Medicaid Business & Policy
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

If you have any questions, please do not hesitate to contact us at (603) 271-4514 or e-mail to achalsma@dhhs.state.nh.us.

Part I: Request for Data

All information provided in these sections and in the separate data element forms is required. This information will serve as criteria for decisions regarding release of the data set. Access to Limited Use Data Sets will be approved only for the purposes of health related research, public health, or health care operations.

Section A: Individual and Organization Requestor Information

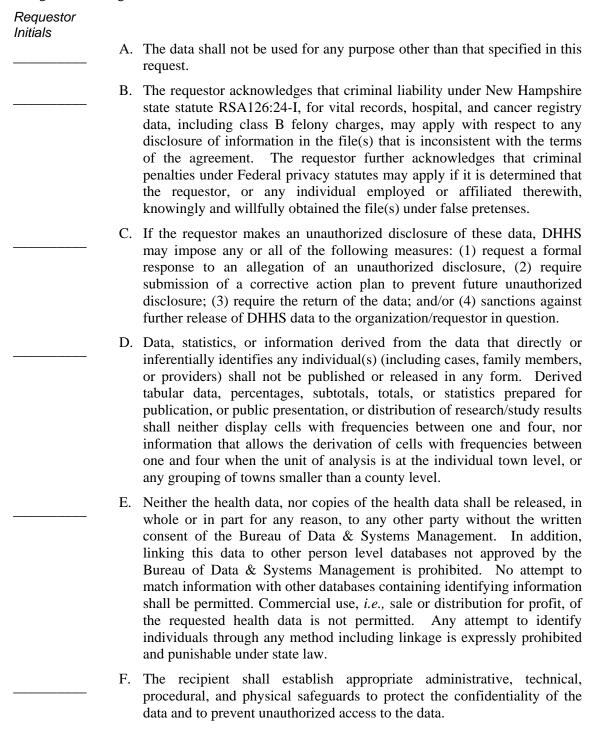| |
|---|
| Contact Person's Name and Title (name of person conducting data analysis): |
| Organization: |
| Address: |
| Telephone Number: |
| Fax Number: |
| E-mail Address: |
| Overall Responsible Party's Name and Title: |
| Overall Responsible Party's Telephone Number: |
| Date: |

Section B: Summary of Research Study Protocol or Project Activities:

Please submit a copy of your research/study/project protocol. Use as much space as you need below to answer the questions. If you are not using this electronic document, attach a separate document with numbered answers.

1. **Overall title of study or project:**

2. **Benefit of study or project.** How will this study benefit New Hampshire residents and/or public health?

3. **Personnel.** Please describe qualifications, or attach a resume, of all staff who will have access to the limited use data files. These include personnel, subcontractors, and affiliated agencies.

4. **Qualifications and affiliation.** For all staff please describe qualifications or attach resumes.

5. **Study background and design.** If available, you may attach your research protocol and skip to Question 7. If this request is not part of a scientific research study, please provide an abstract describing the background and design of the project and the reason for requesting the data. Access to Limited Use Data Sets will be approved only for the purposes of health related research, public health, or health care operations. Please address the following points as fully as possible:

   - a summary of background and purposes of the planned use of the data sets;

   - a statement of the health-related problem or issue to be addressed by using the data;

   - the research design and methodology including either the topics of exploratory research or the specific research hypotheses to be tested;

   - and the intended research completion date, if applicable. If no date is specified, annual updates to the application will be necessary.

6. **Data management.** Please describe the methods used to store the data and how confidentiality of the data will be maintained.

7. **Contact with subjects.** Requests for data for studies that involve contacting or identifying individuals must be not be applied for using this form.   Please state that the study or project activities will not involve contact with any persons who are the subject of the requested data records.

Section C: Requestor Assurances

The undersigned agrees to the following terms and conditions related to using Bureau of Data & Systems Management managed health-related data.

Requestor Initials

_____ A. The data shall not be used for any purpose other than that specified in this request.

_____ B. The requestor acknowledges that criminal liability under New Hampshire state statute RSA126:24-I, for vital records, hospital, and cancer registry data, including class B felony charges, may apply with respect to any disclosure of information in the file(s) that is inconsistent with the terms of the agreement. The requestor further acknowledges that criminal penalties under Federal privacy statutes may apply if it is determined that the requestor, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses.

_____ C. If the requestor makes an unauthorized disclosure of these data, DHHS may impose any or all of the following measures: (1) request a formal response to an allegation of an unauthorized disclosure, (2) require submission of a corrective action plan to prevent future unauthorized disclosure; (3) require the return of the data; and/or (4) sanctions against further release of DHHS data to the organization/requestor in question.

_____ D. Data, statistics, or information derived from the data that directly or inferentially identifies any individual(s) (including cases, family members, or providers) shall not be published or released in any form. Derived tabular data, percentages, subtotals, totals, or statistics prepared for publication, or public presentation, or distribution of research/study results shall neither display cells with frequencies between one and four, nor information that allows the derivation of cells with frequencies between one and four when the unit of analysis is at the individual town level, or any grouping of towns smaller than a county level.

_____ E. Neither the health data, nor copies of the health data shall be released, in whole or in part for any reason, to any other party without the written consent of the Bureau of Data & Systems Management. In addition, linking this data to other person level databases not approved by the Bureau of Data & Systems Management is prohibited. No attempt to match information with other databases containing identifying information shall be permitted. Commercial use, *i.e.,* sale or distribution for profit, of the requested health data is not permitted. Any attempt to identify individuals through any method including linkage is expressly prohibited and punishable under state law.

_____ F. The recipient shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data.

_____   G. The parties mutually agree that the aforesaid file(s) (and/or any derivative file(s) may be retained by the user for one year upon receipt or until the following retention date specified _____. **(Date provided by DHHS**) If more than two years of retention is requested, the data use agreement must be updated and resigned annually. When the year has passed or the retention date expires, the data must be destroyed and the requestor shall so notify the Bureau of Data & Systems Management by letter stating the data has been destroyed.

_____   H. Any report using data or statistics derived from the health data that has been prepared for publication, public presentation, or distribution shall acknowledge the Department of Health and Human Services as the source of data in any and all reports, or publications, or presentations generated by the requestor from these data. The requestor also agrees to specify that the analyses, conclusions, interpretations, and recommendations drawn from such data are solely those of the requestor, and are not necessarily those of the Department of Health and Human Services.

_____   I. PREVIEW CLAUSE. Any reports or publications **must** be previewed by the Bureau of Data & Systems Management to ensure the integrity of the data release policy. This review is intended only to verify the policy and will not examine content, conclusions, or grammar. The preview and response will be done in a timely manner. Responses will be in writing to ensure that this review does not create barriers to dissemination of findings. All requestors will be monitored during the course of their stewardship of the data through a site visit.

I have reviewed the request form. All statements made in the request form are true, complete, and correct to the best of my knowledge, and I agree to abide by the aforementioned rules. Note:Original signatures accepted only.

Name of person conducting data analysis:	Name of overall responsible party:
Title:	Title:
Organization:	Organization:
Signature: Date:	Signature: Date:

Part II: Specification of Request for Limited Use Data

Instructions for using the following checklists:

1. Check ($\checkmark$) dataset(s) requested.

2. Specify year(s) of data requested based on years of data available. Please note that years of available data vary for datasets.

3. Indicate the software format (such as MS Excel, MS Access, ASCII, etc) in which you would like to receive dataset.

4. On the following pages, find the variable listings corresponding to the datasets you requested. On the form(s), indicate fields requested by placing an $\checkmark$ in corresponding box. Please provide a justification for those fields indicated as potential indirect identifiers. *Please remove any checklists that are not applicable.*

Please indicate the type of data and years requested by checking boxes below:

$\checkmark$	*Hospital Discharges*	Years Requested										
		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
☐	Inpatient	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Ambulatory/ED Combined[1]	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Amb. Surgery Only	-	-	-	☐	☐	☐	☐	☐	☐	☐	☐
☐	ED Only	-	-	-	☐	☐	☐	☐	☐	☐	☐	☐
☐	Observation Only	-	-	-	☐	☐	☐	☐	☐	☐	☐	☐
☐	Specialty	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*Note: **Earlier years** of some datasets may be available but are likely to be less reliable and may be more difficult to work with. Please inquire if you are interested in earlier data.*

If your study requires additional years of data beyond those checked above, please indicate years:

Requests for receipt or retention of data beyond two years after receipt of initial data will require annual resigning and resubmission of requestor assurances.

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[1] Until 1999 there is no field that distinguishes ambulatory surgeries and emergency department discharges.

Data will be provided on a CD-ROM. Please indicate how you would like to receive the data (check only one box):

✓ *File Format*		
☐ MS Access (Version, if not 2000_____)	☐ Fixed Length Text File	
☐ MS Excel (Version, if not 2000_____)	☐ Delimited Text File	
☐ SPSS	☐ Dbase III	
☐ SAS		
☐ Other:		

Data will be shipped via UPS or FedEx Next Day Delivery, unless otherwise stated. Please provide your UPS or FedEx billing number and any other relative shipping information.

UPS_____

FedEx_____

Shipping information if different than address given in Part 1, Section A:

New Hampshire Hospital Inpatient Discharge Data Set

Please check the variables you would like included in your dataset. Select only those elements needed for your analysis. Where indicated, provide a justification for need and specify any sub-selection of records or grouping of values you expect to use for each variable. *Please use as much space as you need.*

Need: We will only provide the minimum set of information with the minimum specificity that you need. Variables may be denied if your application does not justify your need explicitly when required.

Sub-selection of Records (Filters): We will only release the minimum set of records needed for your study. Please provide any selection criteria for the records you are specifically interested in. For instance, if you are specifically studying heart disease discharges, be sure to indicate you only require records where the diagnosis met your specified criteria for heart disease.

Grouping of Values: Where relevant, we will provide data elements pre-grouped. Please indicate any grouping that is needed for your study. For instance, if you only need to know the patient's county of residence, indicate that, and we will supply the county instead of the town of residence. Another common example is grouping the patient's age.

Variables	Provide Need, Filters and Groups
☐ Patient date of birth	Need: Filter: Groups:
☐ Patient age	Filter: Groups (e.g., age groups):
☐ Patient age in days if an infant	Filter: Groups:
☐ Patient sex	Filter: Groups:
☐ Patient race	Need: Filter: Groups:
☐ Patient residence town code	Need: Filter: Groups (e.g., state, county, etc.):
☐ Patient ZIP code	Need: Filter: Groups:
☐ Hospital	Filter: Groups:
☐ Year of admission	Filter: Groups:
☐ Month of admission	Need: Filter: Groups:
☐ Day of admission	Need: Filter: Groups:
☐ Day of week of admission (if date not supplied)	Filter: Groups:
☐ Admit hour	Filter: Groups:
☐ Year of discharge	Filter: Groups:
☐ Month of discharge	Need: Filter: Groups:

Variables	Provide Need, Filters and Groups
☐ Day of discharge	Need: Filter: Groups:
☐ Day of week of discharge (if date not supplied)	Filter: Groups:
☐ Discharge hour	Filter: Groups:
☐ Length of Stay	Filter: Groups:
☐ Admission type	Filter: Groups:
☐ Admission source	Filter: Groups:
☐ Patient disposition	Filter: Groups:
☐ Principal diagnosis (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ Secondary diagnoses (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ Principal procedure	Filter: Groups:
☐ Secondary procedures	Filter: Groups:
☐ E-code	Filter: Groups:
☐ Principal procedure date	Need: Filter: Groups:
☐ Principal post procedure length of stay, Principal procedure date – Admit Date (alternative to date fields)	Filter: Groups:
☐ Secondary procedure dates	Need: Filter: Groups:
☐ Secondary post procedure lengths of stay	Filter: Groups:
☐ Diagnostic Related Group	Filter: Groups:
☐ Major Diagnostic Category	Filter: Groups:
☐ Primary payor source	Filter: Groups:
☐ Total charges	Filter: Groups:
☐ Total charges net professional services.	Filter: Groups:
☐ Encrypted patient identification number	Need: Filter: Groups:

New Hampshire Specialty Hospital Discharge Data Set

Please check the variables you would like included in your dataset. Select only those elements needed for your analysis. Where indicated, provide a justification for need and specify any sub-selection of records or grouping of values you expect to use for each variable. *Please use as much space as you need.*

Need: We will only provide the minimum set of information with the minimum specificity that you need. Variables may be denied if your application does not justify your need explicitly when required.

Sub-selection of Records (Filters): We will only release the minimum set of records needed for your study. Please provide any selection criteria for the records you are specifically interested in. For instance, if you are specifically studying a certain type of psychiatric discharges specified by DRG code, be sure to indicate you only require records where the DRG met your specified criteria.

Grouping of Values: Where relevant, we will provide data elements pre-grouped. Please indicate any grouping that is needed for your study. For instance, if you only are studying women, indicate that and we will supply records where the patient was female. Another common example is grouping the patient's age.

Variables	Provide Justification for Need, Filters, Groups
☐ Patient date of birth	Need: Filter: Groups:
☐ Patient age	Filter: Groups (e.g., age groups):
☐ Patient sex	Filter: Groups:
☐ Patient race	Need: Filter: Groups:
☐ Patient ZIP code	Need: Filter: Groups:
☐ Hospital	Filter: Groups:
☐ Year of admission	Need: Filter: Groups:
☐ Month of admission	Need: Filter: Groups:
☐ Day of admission	Need: Filter: Groups:
☐ Day of week of admission (if date not supplied)	Filter: Groups:
☐ Year of discharge	Filter: Groups:
☐ Month of discharge	Need: Filter: Groups:
☐ Day of discharge	Need: Filter: Groups:
☐ Day of week of discharge (if date not supplied)	Filter: Groups:

Variables	**Provide Justification for Need, Filters, Groups**
☐ Length of stay	Filter: Groups:
☐ Admission source	Filter: Groups:
☐ Patient disposition	Filter: Groups:
☐ Principal diagnosis (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ Secondary diagnoses (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ E-code	Filter: Groups:
☐ Diagnostic Related Group (DRG)	Filter: Groups:
☐ Major Diagnostic Category (MDC)	Filter: Groups:
☐ Primary payor source	Filter: Groups:
☐ Total charges	Filter: Groups:
☐ Total charge net professional services	Filter: Groups:
☐ Encrypted patient identification number	Need: Filter: Groups:

New Hampshire Hospital Ambulatory Care Data Set

Please check the variables you would like included in your dataset. Select only those elements needed for your analysis. Where indicated, provide a justification for need and specify any sub-selection of records or grouping of values you expect to use for each variable. *Please use as much space as you need.*

Need: We will only provide the minimum set of information with the minimum specificity that you need. Variables may be denied if your application does not justify your need explicitly when required.

Sub-selection of Records (Filters): We will only release the minimum set of records needed for your study. Please provide any selection criteria for the records you are specifically interested in. For instance, if you are specifically studying injury discharges, be sure to indicate you only require records where the diagnosis (or E-code) met your specified injury criteria.

Grouping of Values: Where relevant, we will provide data elements pre-grouped. Please indicate any grouping that is needed for your study. For instance, if you only need to know the patient's county of residence, indicate that, and we will supply the county instead of the town of residence. Another common example is grouping the patient's age.

Variables	Provide Justification for Need, Filters, Groups
☐ Patient date of birth	Need: Filter: Groups:
☐ Patient age	Filter: Groups (e.g., age groups):
☐ Patient age in days if an infant	Filter: Groups:
☐ Patient sex	Filter: Groups:
☐ Patient ZIP code	Need: Filter: Groups:
☐ Patient residence town code	Need: Filter: Groups (e.g., state, county, etc.):
☐ Hospital	Filter: Groups:
☐ Year of admission	Filter: Groups:
☐ Month of admission	Need: Filter: Groups:
☐ Day of admission	Need: Filter: Groups:
☐ Day of week of admission (if date not supplied)	Filter: Groups:
☐ Admit hour	Filter: Groups:
☐ Year of discharge	Filter: Groups:
☐ Month of discharge	Need: Filter: Groups:
☐ Day of discharge	Need: Filter: Groups:

Variables	Provide Justification for Need, Filters, Groups
☐ Day of week of discharge (if date not supplied)	Filter: Groups:
☐ Discharge hour	Filter: Groups:
☐ Length of stay	Filter: Groups:
☐ Patient disposition	Filter: Groups:
☐ Principal diagnosis (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ Secondary diagnoses (please indicate ICD9 code range you are requesting)	Filter: Groups:
☐ E-code	Filter: Groups:
☐ Principal procedure	Filter: Groups:
☐ Secondary procedures	Filter: Groups:
☐ Principal procedure date	Need: Filter: Groups:
☐ Secondary procedure dates	Need: Filter: Groups:
☐ Diagnostic Related Group (DRG)	Filter: Groups:
☐ Primary payor source	Filter: Groups:
☐ Total charges	Filter: Groups:
☐ Total charges net professional services.	Filter: Groups:
☐ Encrypted patient identification number	Need: Filter: Groups:
☐ Patient type (**1999 and later only**, distinguishes between Outpatient Surgery, ED, Observation, Other). Please call us with questions.	☐ Outpatient Surgery ☐ ED ☐ Observation ☐ Other

Rev September07
T:OMBP/Application Forms